Don't give up giving up.

NHS

The Provision of Stop Smoking Interventions in General and Psychiatric Hospital Settings

A Service Delivery Toolkit

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Preface

Smoking affects us all. For the smoker, it is a major cause of death and disability, with 5 million worldwide dying prematurely each year as a result of smoking. For those who live with smokers, there is a significantly higher risk of developing heart disease or lung cancer. Finally, for the UK as a nation, smoking is expensive in terms of both the financial impact of treating diseases caused by smoking and the lost productivity caused by absenteeism amongst smokers due to ill-health.

The 2004 White Paper "Choosing Health" emphasises the need to "mainstream a comprehensive approach to health improvement across the NHS from primary care, through hospital care to specialist services."

Hospital based services can play an important part in this support structure, as hundreds of thousands of people pass through our services each year, either as in-patients or as out-patients. Importantly, they will come to hospital with their health on their mind, and more open to changing their lifestyle for the better. They may also be required to temporarily stop smoking in order to facilitate their care; a compulsory abstinence that, with the right support and advice, can become a permanent one.

This Service Delivery Toolkit is based on the experience of implementing stop smoking programmes within three NHS hospital settings as part of the Reduction in Tobacco Addiction (RETAD) action research project. The emphasis throughout is on direct, simple solutions and the utilisation of existing resources. The intention is that it will serve as a resource for those wishing to implement similar programmes and provide guidance on the structures that need to be put in place and the challenges that are likely to arise.

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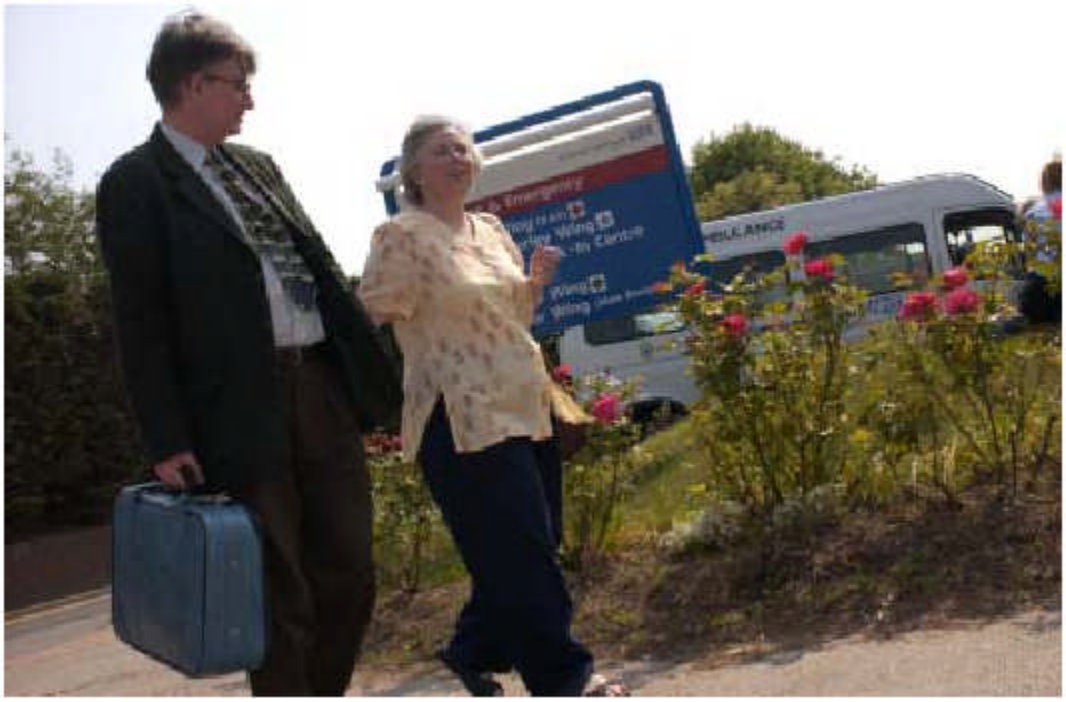
1. Introduction and Overview

OBJECTIVES

- **To examine the context of hospital-based stop smoking services**
- **To describe the aims and objectives of the toolkit and its target audience.**
- **To provide guidance on how the toolkit may be used.**
- **To provide an overview of the toolkit.**



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1.1 Background

It is generally acknowledged that smoking is the single most preventable cause of death and disability. Approximately 114,000 people in the UK are killed by smoking every year (one fifth of all UK deaths) (Peto,2003) and by 2006, the estimate is 115,000 http://www.deathsfromsmoking.net/

From a national perspective, smoking related costs to the NHS annually have been estimated to be about £1.5 billion (Parrot et al., 1998). In "Smoking Kills: A White Paper on Tobacco" (Secretary of State for Health, 1998) a major aim was the reduction of tobacco related diseases.

1.1.1 Stop Smoking Services in Hospital Settings

Within the White Paper "Choosing Health: Making healthier Choices Easier" (Secretary of State for Health, 2004) the need for "ensuring that the one and a half million contacts people have with the NHS every day become opportunities for improving and promoting health" is highlighted.

The Department of Health document "National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06–2007/08" reccomends that "health care organisations have systematic and managed disease prevention and health promotion programmes" including those that address smoking.

In 2003, only 53% of hospitals included in a UK survey were reported to have hospital-based smoking cessation services (British Thoracic Society, 2003)

Patients in hospital represent a sizeable and potentially viable sector of the population for stop smoking intervention. The "Choosing Health" white paper highlights that there are 96,000 emergency admissions and 38,000 elective admissions to UK hospitals each day.

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Admission into hospital may, for many patients, cause a positive shift in the importance they attach to health issues. This may potentially act as a trigger towards permanent changes in lifestyle, particularly if supplemented by appropriate stop smoking interventions. In addition, many, patients entering hospital are required to abstain from smoking in order to facilitate their care. Provision of appropriate pharmacological and psychological support at this time may help dispel many of the fears patients hold about living without smoking (e.g., severe withdrawal symptoms) and provoke a long term, voluntary abstinence.

There has been a call for more resources to be devoted to cessation efforts within the mental health patient population (HDA, 2004). Despite their higher rates of smoking, a substantial proportion of smokers with mental health problems are motivated to quit, (McNeill, 2001). Studies of stop smoking interventions indicate that they are as successful among mental health patients as among the general population (el-Guebaly et al., 2002).

1.1.2 Service Implementation and Smoke Free Policy

The White Paper, *Choosing Health*, makes clear that "by the end of 2006… the NHS will be smoke-free" (DH, 2004). In London, many NHS organisations have brought this target forward and are aiming to be smoke free environment by the end of 2005. This is generally a popular move, with 84% of respondents in a recent survey indicating that they wanted hospitals to be completely smoke free (MORI and Smoke Free London 2003). However, smoke free policy does also have its opponents, maybe no more so than in mental settings.

While the purpose of this toolkit is to act as a resource for the implementation of stop smoking intervention rather than smoke free policy, the current saliency of policy issues requires that they be addressed here to some extent. Therefore, the relevance of smoke free policy to hospital based cessation programmes is discussed (see sections 5.2.1 and 5.2.2) as well as the particular implications of smoke free policy in mental health settings (see section 5.3.4)

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1.1.3 Production of the toolkit

The Reduction in Tobacco Addiction (RETAD) programme is the first of its kind in the United Kingdom. Its main was to develop a multi-component, multi-setting intervention focussing on motivating smokers to quit. The experiences gained from implementing and running the pilot programme has formed the basis for this service delivery toolkit. Coordinated within St. George's Hospital Medical School, London, the programme has been implemented across three large NHS Trusts and brought together experts from a range of areas including medicine, nursing, psychology and NHS stop smoking services.

1.2 Aims of the Toolkit

This service delivery toolkit sets out clear and structured guidance for those wishing to implement stop smoking interventions within a hospital setting. Hospital services are seen as incorporating not only in-patient care, but also any out-patient clinics and community services within the hospital organisation.

The objectives are to provide direction on the structures that need to be put in place for service implementation; identify some of the challenges that are likely to arise; and to make suggestions as to how these may be addressed.

The focus of the toolkit is on providing direct, simple solutions that make efficient use of existing health care resources.

The place of a hospital-based service within the larger health service structure is taken into account, and the importance of effective collaboration with related service providers is emphasised throughout.

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1.3 Who is the toolkit for?

The intention is that this toolkit will serve as a resource for those at a managerial and / or senior clinical level in both general and psychiatric health care settings. The intended audience includes NHS trust executives, medical and nursing directors, hospital managers and stop smoking service coordinators.

In addition to being of interest to those directly involved in hospital-based services, the toolkit is also aimed at anyone wishing to extend stop smoking services based in other settings (e.g., Primary Care Trusts) to local hospital sites.

1.4 How to use the toolkit

The toolkit is intended as a flexible resource that can be used in a number of ways.

Its primary function is to serve as a comprehensive guide to the implementation of a hospital based stop-smoking service. Therefore, the intention has been to provide information in a logical and useful order, beginning with the structures that need to be put in place at the outset, then moving on to issues around programme implementation, and ending with suggestions on how to overcome the problems that may arise once a service is underway.

The toolkit is also intended as a reference guide for those already engaged in providing hospital based stop smoking services who may wish to find answers to specific questions or problems. With this aim in mind, the toolkit has been designed in a way that allows information on specific topics to be accessed easily. It is supplemented by a 'frequently asked questions' section and provides a number of resources in the appendix including assessment tools and a guide to other sources of information.

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1.5 Overview

From this introduction, the toolkit will move on in *chapter two* to examine the place of a hospital-based service within the overall stop smoking service structure. Rather than remaining static, patients (including those wishing to quit smoking) will constantly move around within the health service structure. Therefore, effective linkage and collaboration with other, community based services is a necessary consideration and crucial to the provision of a coherent system of stop smoking support.

In *chapter three*, the task of establishing the necessary infrastructure for a stop smoking service is considered. An emphasis is placed upon a multi-disciplinary approach that incorporates expertise from a range of healthcare disciplines, and locates the stop smoking service firmly within the existing infrastructure of an organisation.

This multi-disciplinary emphasis continues in *chapter four*, which highlights some issues that will be important considerations in the initial implementation of a stop smoking programme. Wherever possible, the recommendations focus on the use of existing resources, such as establishing an in-house training system, so as to lower overall costs.

Chapter five considers some of the challenges that may arise when implementing a hospital based stop smoking programme, as well as recommendations for addressing those challenges. Consideration is given to challenges that may arise in all hospital based environments, as well as those more likely to arise within psychiatric settings. In making recommendations, the focus has been on finding as direct a solution as possible, and again, on utilising existing resources.

The toolkit concludes, in *chapter six*, with a series of 'frequently asked questions'. This section allows the reader to quickly and easily obtain information and guidance on a range of specific issues. This section is fully cross-referenced to the rest of the toolkit so that more detailed discussion on an issue maybe accessed directly.

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2. Hospital-based Services within the Stop Smoking Service Structure

OBJECTIVES

- **To outline the structure of stop smoking services in the UK.**
- **To explore potential links between a hospital based stop smoking service and other services.**
- **To offer guidance on effective collaboration with other services.**

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2.1 The structure of stop smoking services in the UK

The Health Service Circular 1999/087 first directed Health authorities to set up stop smoking services. This section offers an overview of the principles of service delivery and likely issues encountered. It is important that opportunities for individuals to stop smoking are provided and integrated into all parts of the health service but the actual configuration of a service will be determined locally.

2.1.1 Overview

Stop smoking services or interventions are generally categorised into three levels:

Level 1: involves a routine enquiry to all patients on their smoking status and readiness to quit. Advice to quit should be clear and tailored to the individual's health. Information on the availability of stop smoking services should be offered. Ideally all front line staff should receive Level 1 training.

Level 2 (or intermediate advice): involves a health professional supporting an individual through the quitting process. Training to undertake this role generally takes 2 days. Information about this training is available through the local stop smoking service. Training programmes should meet the standard laid down by the Health Development Agency.(functions of HDA transferred to NICE April 2005) Individuals working at Level 2 often do this as part of another role (e.g. practice nurses). However it is important that they have dedicated time to give to the role.

Level 3 (or specialist level): this involves supporting individuals to quit in a group setting following a withdrawal-oriented approach. These clinics are generally seven weeks in duration and support those attending until they have quit for 4-weeks. Those working at this level may also be involved in training.

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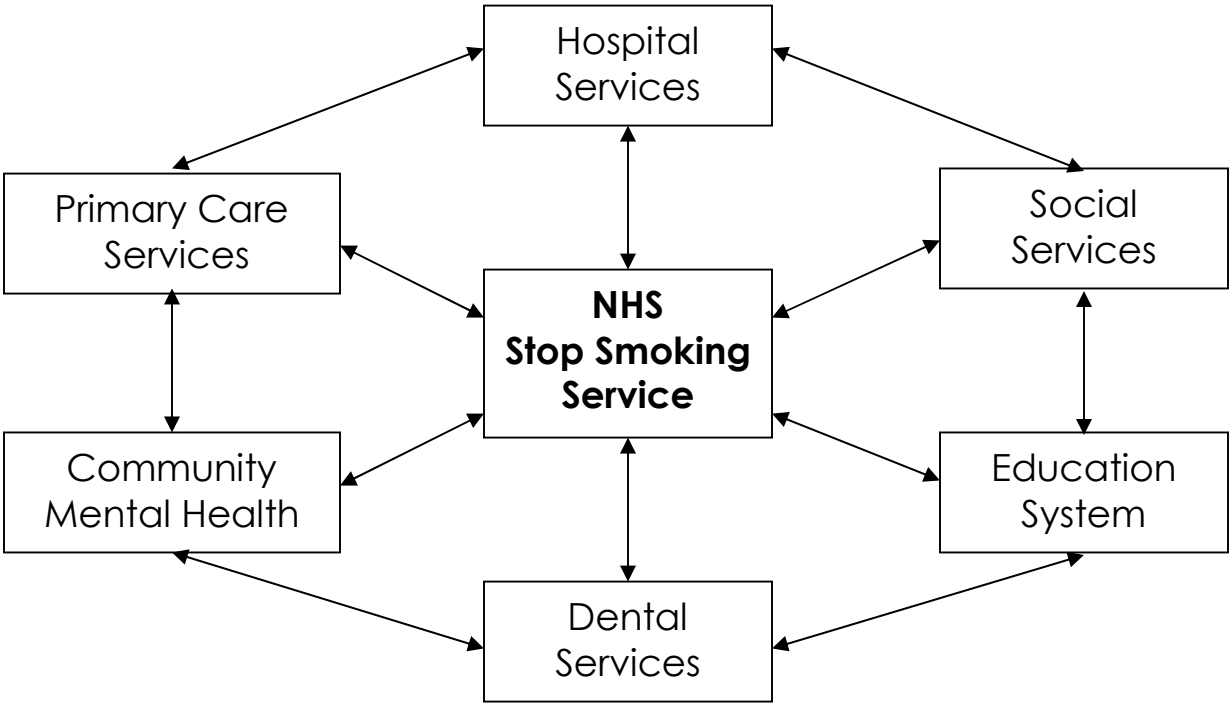
2.1.2 The place of the hospital based service within the stop smoking service structure.

Hospitals, including both in-patient and out-patient services, should be seen as an essential component of an overall approach to stop smoking services within the local community (see section 1.1.1). Figure 1 illustrates the place of a hospital within a structure of organisations able to offer stop smoking support. This illustration is not meant to be exhaustive, and other local agencies not specifically identified may play a part in an overall stop smoking strategy.

Figure 1: Stop smoking service structure



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The approach to stop smoking support within a hospital should acknowledge that the hospital structure reaches beyond patients to staff and carers / visitors, all of whom can benefit from stop smoking support and intervention.

In order that the place of a hospital within a stop smoking service structure not be undermined, it is an increasing priority to ensure hospitals are in a position not only to give clear messages to individuals as smokers, but also to set an example in relation to the hospital environment.

In the UK and Republic of Ireland (Eire), smoke-free legislation has been introduced which bans smoking in enclosed public or work places (including vehicles). The Health Act 2006 (HMSO) applies to England and Wales, and grants authority to make regulations, respectively to the Secretary of State for England, and to the National Assembly of Wales.

While *The Smoke-free premises etc. (Wales) Regulations (2007)* provides exemption to mental units from being smoke-free, (paragraph 4, section a), the English *Smoke-free (Exemptions and Vehicles) Regulations (2007)* only gave a temporary, one year exemption to mental health units.

Accordingly, from 1st July 2008 in England smoking is not permitted in any NHS buildings or vehicles. This applies to patients, staff, visitors, and contractors working on the premises. NHS staffare not permitted to smoke when on NHS Trust business, for example visiting patients in the community. Adherence to no smoking policy is addressed further in section 5.2.1 of this toolkit.

During the process of creating a smoke-free environment it is vital that the needs of smokers are considered whilst they are forced to stay in a smoke-free environment. Many smokers will use the opportunity to make a quit attempt and those that do not wish to try

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and quit should also be offered the opportunity to receive nicotine replacement therapy (NRT) if they are suffering from withdrawal symptoms.

This will alleviate the risk of secret smoking and on occasion can lead to a successful quit attempt. It is important that these wider issues are considered when developing a hospital-based service.

Experience has shown that hospital staff often have real constraints in their ability to follow through and support individual patients. The provision of some dedicated time to deliver interventions at ward level must be considered.

2.2 Establishing effective collaboration with other services

If a hospital is considering the development of a stop smoking service it is important that contact is made with the local stop smoking service for advice and support rather than operate as a separate initiative. Indeed, local stop smoking services are likely to be fundamental within the infrastructure and coordination of a hospital-based stop smoking programme (see section 3.1).

Linking to local stop smoking services is the key to developing a hospital service that integrates with other community services. The key to successfully supporting smokers to stay stopped once they have set their quit date in hospital is the continuation of support upon discharge. For many smokers this is like a second quit date, as all the normal triggers to smoke return to their life when they are at home.

In a hospital, everyday triggers are often missing which may create an advantage for the smoker wishing to quit. If the service set up within the hospital is not able to follow patients on discharge a robust system must be put in place to ensure that these individuals are identified and supported by the community service for at least 4-weeks post quit date.

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3. Establishing the Infrastructure for a Hospital Based Stop Smoking Service

OBJECTIVES

- To provide a framework for a hospital based stop smoking service and discuss its individual elements
- To provide guidance on the operation of a service infrastructure, including staff training and monitoring
- To outline a framework for the resource planning and management required for a hospital based stop smoking service

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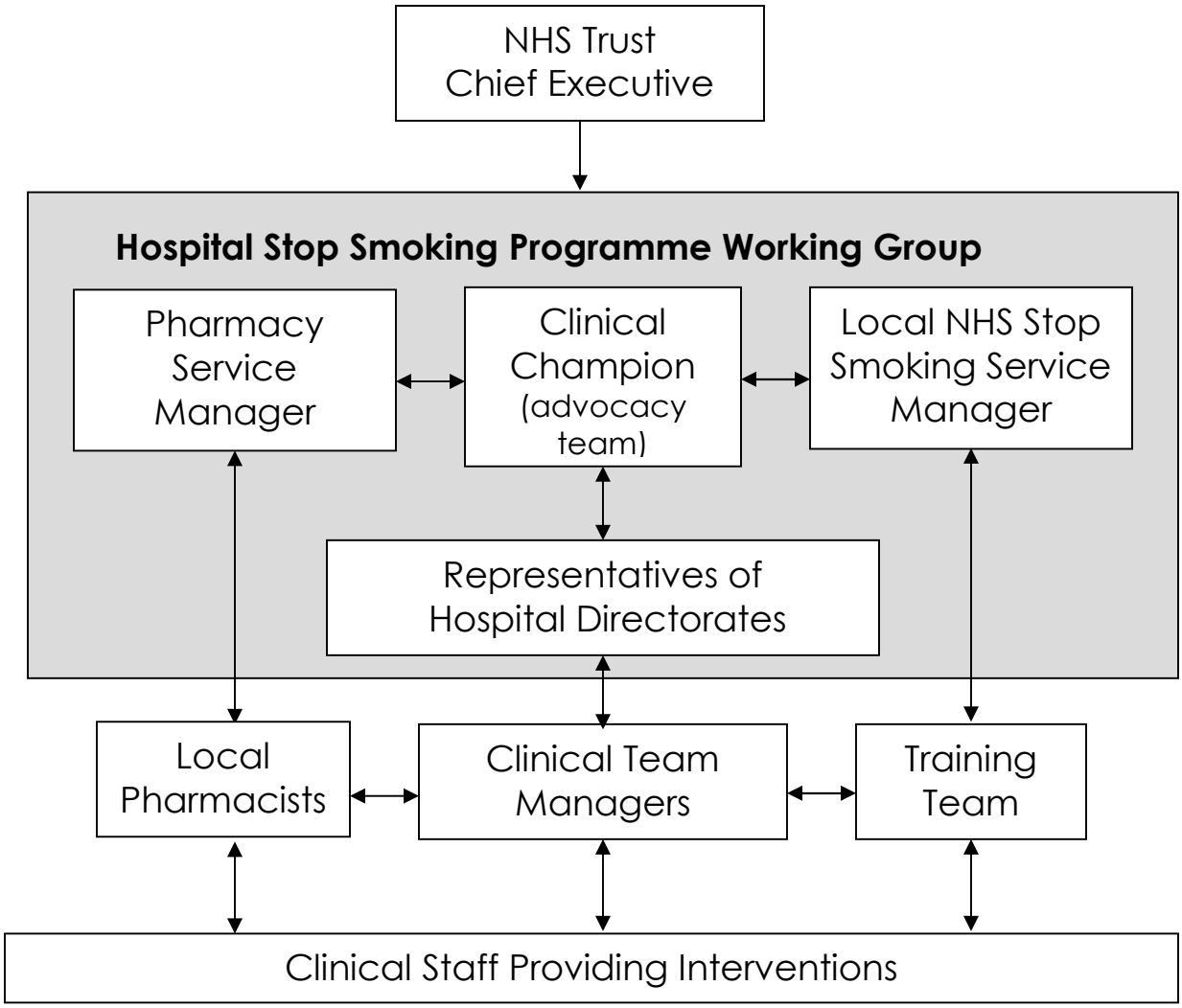
3.1 Programme Co-ordination

A possible infrastructure for the coordination of a hospital based stop smoking programme is illustrated in figure 2. The various features of this infrastructure are discussed in more detail in the following sections.

Figure 2: A possible hospital-based stop smoking service infrastructure



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A hospital-based programme should be seen as part of the overall, local stop smoking service strategy rather than as a separate initiative.

It is expected that the Chief Executive of the NHS Trust concerned, in close collaboration with the local NHS stop smoking service, will provide overall leadership in the implementation of the hospital based stop smoking programme.

A 'clinical champion' (see section 3.2), with the full support of the Chief Executive, should play an ongoing and central role in the coordination of the programme. He or she will be able to mobilise support from within hospital staff as well as ensure effective collaboration between managerial and clinical teams.

In co-ordinating a programme, appropriate involvement and consultation should take place with representatives from all specialities of general medical services, psychiatry, psychology, nursing, pharmacology health care management and other relevant disciplines.

3.2 Identifying a 'Clinical Champion'

The Identification of an effective 'clinical champion' is fundamental to the successful implementation of a hospital based stop smoking programme within an existing health care service structure.

An effective clinical champion is likely to be a senior clinician of influence within the hospital or local NHS Trust. It is essential that the clinical champion have a demonstrable interest in smoking related work.

The role of the clinical champion is that of an advocate within the NHS Trust. He or she will be able to promote the stop smoking programme throughout the organisation, and

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encourage participation and enthusiasm at a senior level (e.g., across consultants and ward managers).

While in many cases the most effective clinical champion would be a physician, in many other organisations another senior clinician may be better placed to fulfil this role. In particular, nurse consultants or nursing directors may be better able to bring the necessary resources and people together, as may be the case for a senior clinical or health psychologist, or a senior member of the pharmacy department. The choice of clinical champion is best made on the basis of commitment and experience rather than professional background.

3.3 Establishment of a multidisciplinary working group

Stop smoking programmes in hospital settings can benefit from the establishment of a working group that can implement and oversee the programme across disciplines or directorates.

A 'clinical champion' (see section 3.2) should ideally chair the working group, which should also include representatives from each of the directorates to be covered by the programme, as well as representatives of local pharmacy services and the local NHS stop smoking services.

.

Directorate representatives are, along with the 'clinical champion', responsible for advocating the stop smoking programme throughout the organisation. Each representative take should responsibility for implementation of the programme within their directorate. They should also take responsibility for implementing and overseeing a system of progress monitoring (see section 3.6).

If a programme is to be conducted over several sites within a Trust, satellite sites will benefit from the establishment of smaller, local working groups. This allows issues specific

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to each particular site to be discussed at a local level, which in turn will allow barriers to be addressed more efficiently.

Each local working group should be represented by at least one member at all meetings of the Trust-wide, central working group.

3.4 Establishment of an infrastructure for programme organisation

Decisions on programme procedures are taken within the central working group and enacted through directorate representatives and local working groups where applicable.

Directorate representatives oversee the implementation of the programme in conjunction with individual clinical team managers. Clinical team managers are responsible for the programme within their team or ward.

The responsibilities of clinical team managers include organising the stop smoking work within the team, collecting data on progress as part of an ongoing monitoring system (see section 3.6) and providing input into staff training (see section 3.5).

3.5 Establishment of an infrastructure for staff training

In establishing an infrastructure for staff training, training systems should be organised and maintained as part of the overall strategy of the local NHS stop smoking services and not as a completely separate, hospital-based initiative.

A training team should be set up centrally within the organisation. These trainers should have successfully completed appropriate courses in all levels of stop smoking interventions (see section 4.7), as well as an appropriate 'training for trainers' course covering the skills needed for effective staff training.

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The training team should be made up of staff members from all directorates covered by the programme.

Clinical team managers should be responsible for referring individual staff members for training team at the start of their employment, or in the case of existing staff, when further training needs arise.

3.6 Establishment of a programme monitoring system

A monitoring system should be established that provides data on progress within the hospital based stop smoking programme.

This system should be established and maintained in accordance and collaboration with the local, community based stop smoking service.

Local stop smoking services have their own guidance for monitoring set down by the Department of Health. A hospital-based service monitoring system should be integrated into the existing monitoring structure.

The monitoring system should include ongoing data collection on the number of staff trained and the number of interventions delivered.

The monitoring system may also address the number of smokers coming under the care of each team, the number of referrals made to external smoking services and the number of patients requesting pharmacological support (i.e. NRT / bupropion).

Clinical team managers should be responsible for collecting data within their team and report this information periodically to the directorate representative.

Data from individual directorates should be collated and analysed centrally in order to inform the decision making of the central working group.

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3.7 Establishing a system for pharmacological support

Pharmacological therapy, using nicotine replacement therapy (NRT) and / or bupropion (Zyban) is an important factor in any stop smoking programme (see section 4.8).

A hospital based stop smoking service should actively engage the hospital and community pharmacists.

Issues that need to be agreed with pharmacy teams include the type of products that will be made available to patients, as well as how funding for these products will be organised.

All wards will need to ensure that they have a minimum supply available to meet patient demand.

Recent changes in UK legislation have facilitated the supply and administration of prescription only medicines by designated by staff other than doctors. This system requires the setting up of a “Patient Group Direction" (PGD), a document (signed by a doctor or dentist) that states the circumstances in which the medicine can be supplied. It also lists those excluded from treatment, circumstances in which further medical advice should be obtained, and details any required follow-up action and record keeping.

A PGD can aid the smooth running of a smoking cessation service with the context of a busy hospital environment in which medical staff may only have limited time to devote time to smoking cessation work. It also allows the advisor a more involved role in the intervention, possibly having the effect of increasing their own self-efficacy as interventionists. While Nicotine is a relatively safe medication however, a PGD should be utilised carefully and full training given to those professionals who will operate under the direction. Careful monitoring will also be required of medications prescribed and outcome.

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3.8 Resource Planning

The NHS Trust wishing to implement a hospital based stop smoking programme will need to ensure that the annual budget includes costing that will enable smoking interventions to be delivered successfully.

The Director of Finance must ensure that adequate resources are available to facilitate programme implementation, including staff training, pharmacological treatment and any costs incurred through the co-ordination by the central working group.

During the first year of development, a particular area for consideration may be the additional funding needed to facilitate staff training across the organisation.

Costs related to training may include overtime payments or agency staff costs to cover the shifts and rotas during the initial roll out of training to all health care professionals. This would be costed as one day per staff member to be trained in the first year.

The Trust may need to have a contingency plan for unforeseen costs that might arise as a result of an organisational wide change, such as an increase in the use of NRT products

Checklist of Issues to consider in Resource Planning

- Training staff and associated costs (course costs, staff cover)
- Pharmacological support (cost of medication)
- Committee work (e.g. refreshments for meetings, administrative support for minute taking)
- Marketing costs (posters advertising training, local newsletters/bulletins and stop smoking messages)
- Research and development (small fund to undertake small audits / development work to monitor effectiveness, performance and outcomes).

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4. Implementation of a Hospital Based Stop Smoking Service

OBJECTIVES

- To identify key stages in the implementation of a hospital based stop smoking service
- To offer guidance on key areas of implementation, including training and self-assessment
- To examine the 'journey' of patients through a hospital based service and beyond

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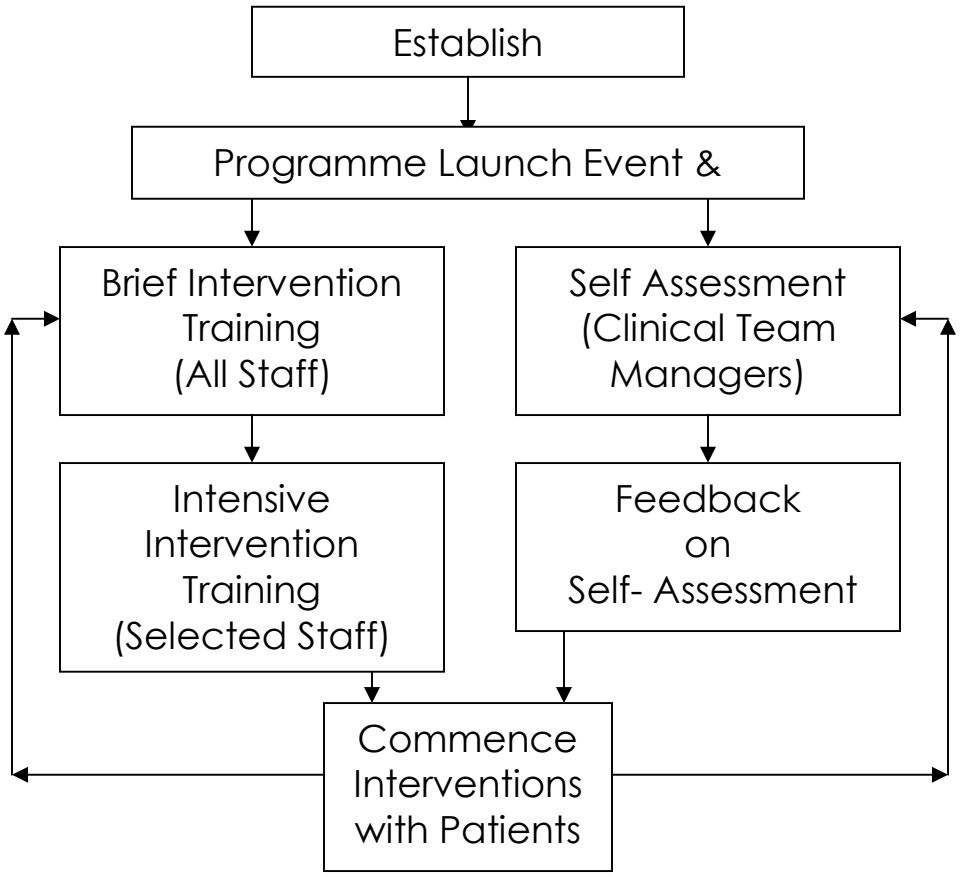
4.1 Key stages in the implementation of a hospital based stop smoking service

There are a number of important stages in the process of implementing of a hospital-based stop smoking service. Several of these stages must inevitably precede the actual intervention work with patients.

Stages in the implementation of a hospital based service including those relating to staff training and self-assessment within clinical teams (in relation to feasibility and barriers to successful implementation). These are discussed in detail in the following sections.

Figure 3 provides an outline of some of the key stages in the implementation of a hospital-based stop smoking service.

Figure 3: Stages in the implementation of a hospital-based stop smoking service



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4.2 Programme Launch

The importance of successful implementation of a stop smoking programme and adopting a stop smoking culture across an NHS organisation will require planning and preparation for a start date.

Working towards a launch date can be a successful approach of organisational ownership. The multi-disciplinary working group should plan the launch date to capitalise on organisational ownership and demonstrate commitment from senior managers of the organisation, stakeholders and the local community.

A launch date may be planned to coincide with another important date in the NHS calendar or for the organisation, such as the already established events of 'No Smoking Day' or 'World Heart Day'.

A launch may take the shape of a special event such as a seminar on the subject or a special lecture from an eminent expert in stop smoking. This event may benefit from publicity in the local press and in the Trust's newsletter.

4.3 Self-assessment within clinical teams

The implementation of a hospital based stop-smoking service entails ownership by the clinical teams where the service will operate. Experience in setting up such services in a variety of health care settings shows that there are a number of key factors or preconditions that need to be considered if implementation is to be successful. These factors may be identified through a self-assessment exercise within clinical teams.

It should be noted that clinical team assessment should be undertaken in the context of a multi level review of the organisations readiness for implementation of stop smoking

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services. Aspects such as training, teamwork, the hospital environment and resource issues are key factors and are discussed elsewhere in this toolkit.

Hodgson (1997) identified a number of important preconditions that, if in place, will facilitate the introduction of a stop smoking programme within a team:

- Team commitment: The whole team is genuinely committed to improving its delivery system.
- Programme champion: A respected member of the team, ideally a GP or a consultant, has offered to be a 'champion', with sufficient clout to overcome obstacles and gain the support of staff at all levels.
- Programme co-ordinator: A member of the team has personally volunteered to act as co-ordinator, assuming responsibility for ensuring that everyone does their tasks and that the service is delivered consistently, effectively and sustained.
- External facilitator: The team is willing to have someone outside the team to facilitate the improvement process.

Other issues that have been have been identified include:

- Is a system in place to routinely identify whether a patient smokes or not?
- Is there a multi-disciplinary team to dedicate time and responsibility to a program of smoking cessation counselling?
- Is there existing provision of education and/or feedback to staff pertaining to stop smoking counselling and other treatments?

Intervention, response and staff views may vary between teams and types of teams. In order to ensure that a certain universality is achieved across team, a number of issues may also need to be assessed when implementing a stop smoking service. This will include:

- All staff should be aware of the signs and implications of nicotine withdrawal.
- All staff should be aware of the management of nicotine withdrawal.
- Sharing of good practice will enable universality.

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- NRT should be available regardless of speciality.
- Awareness of a wards smoking culture e.g. staff smelling of tobacco, talking about "social smoking".
- Awareness of how clinical teams address smoking behaviour, persuasion is better than discrimination.

A self-assessment tool for team managers involved in implementing smoking cessation services can be found in the appendix of this toolkit. It can be modified for management or clinical team use.

4.4 Staff Training

In order to provide a comprehensive and coherent hospital based service, the aim should be to train all appropriate staff within the organisation in some level of stop smoking intervention. This is consistent with the "Choosing Health" White Paper in which it was stated "Every member of NHS staff has the potential to increase their role in raising people's awareness of the benefits of healthy living" (Secretary of State for Health, 2004).

Training should be organised and delivered as part of the overall strategy of the local stop smoking services and not as a completely separate, hospital-based initiative.

Staff appropriate for training will be fully qualified health care professionals who have regular and ongoing patient contact. Appropriate professionals include medical doctors, nurses, social workers, occupational therapists, counsellors, psychologists and pharmacists.

Nursing assistants and other staff members at training grades may also train and provide interventions if approved by a senior member of the clinical team according to a trust-wide strategy.

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An initial training drive should be organised with the aim of training all existing, appropriate staff in the provision of brief interventions (see section 4.7.1). Attendance of staff at training should be the responsibility of directorate representatives in conjunction with clinical team managers and the training team.

In addition to training all staff in brief intervention; selected staff should receive additional training in more intensive interventions that go beyond brief advice (see section 4.7.2). This multi-level approach is more likely to be consistent with the varying levels of need for support among patients wishing to quit smoking.

Following the initial training drive, a regular schedule of training courses should be conducted. These training courses can be aimed at new staff members as well as any existing staff referred (or referring themselves) for extra training.

In addition to the ongoing training sessions, a system of 'top-up' or refresher sessions for trained staff should be organised, within directorates, by a member of the training team. In these meetings, staff can be given the opportunity to discuss issues related to intervention delivery, as well as keep up to date with new developments in stop smoking.

4.5 Staff Support Systems

Support for staff involved in stop smoking intervention delivery is essential. It is important to remember that all staff are involved and equally important. Whilst trained interventionists may be key to delivering more intensive interventions it is important to support a culture of change with all staff.

It should be noted that stop smoking interventions may not have previously been be part of routine care for many staff. Therefore, support from experienced staff is invaluable.

Examples of support include:

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- Information sharing, good practice examples among peers and other ward based staff.
- Corporate support and a clear message from the Trust.
- Team managers taking a lead.
- Supporting time out.
- Follow up training.
- Providing supplementary information.
- Written material, articles, newsletters, posters etc.
- Web based resources and links.
- Electronic newsletters and bulletins.

Staff involved in prescribing may need support in terms of assessment, information about products and patients. They are key members of the team but may be in a post that involves rotation to other areas.

Important consideration should be given to staff that may be involved in a quit attempt themselves. It is important that these staff are identified and that particular attention be given to how the intervention work is affecting their own attempts to give up smoking.

Occupational health departments have a role in the support of staff wishing to quit. At the very least, brief smoking cessation intervention and referral to the stop smoking service should be worked into the routine contact of occupational health personnel with staff. Ideally, this should form part of the assessment carried out with new staff on joining the organisation. Additionally, as occupational health staff are likely to be well positioned to have contact and advise staff who smoke, they may become more involved in the process and train to offer intensive support throughout a staff members' quit attempt (as registered stop smoking advisors). This would remove the need for staff members to take further time to contact and attend the stop smoking service directly.

Particular consideration is also needed for staff had experience of smoking related illness. They may have been ill themselves or experienced the illness or even death of a close friend or relative from a smoking related condition.

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4.6 Patient Assessment

Before stop smoking interventions are delivered to a patient it is recommended that at least a brief assessment of some smoking related factors be carried out.

Patient assessment may inform the provision of the intervention as well as facilitate the evaluation of change if this is desired by the organisation.

The patients smoking status should be assessed in all cases, including the amount smoked per day, as well as their smoking history (including previous quit attempts).

The patient's level of nicotine dependence may also be assessed. The most widely used is the Fagerström Test for Nicotine Dependence (FTND) (see appendix 3). The FTND takes into account not only the level of consumption (cigarettes per day) but also patients' difficulty in situations where smoking opportunities are reduced or absent.

Also informative to the provision of stop smoking intervention may be some assessment of a patient's 'readiness for change' (see appendix for scales*). This takes into account not only how important a patient feels it is to quit, but also how confident he or she feels about succeeding in quitting.

4.7 Intervention

In order to meet the varying needs and circumstances of patients who smoke, various levels of stop smoking intervention have been identified. Included in this approach are both brief (level 1) and more intensive (level 2) interventions.

While a detailed description of the content of intervention and the training programmes related to them are beyond the scope of this toolkit, an overview of their aims and general approach is provided in the following sections.

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4.7.1 Brief Intervention

Brief interventions should be offered to all patients using a hospital service who smoke.

Overall, the aim of a brief ('level one') intervention is to raise the issue of smoking with patients and move them on in terms of thinking about quitting.

The first specific aim within a brief intervention is to ask questions and assess the patient's smoking status, and their readiness to quit.

This, in turn, will influence the focus of the second aim of the brief intervention, which is the giving of information and advice on smoking. The focus should be on the health risks of smoking as well as the benefits of quitting.

The third aim is to provide assistance to the patient regarding quitting. One important way of doing this is informing patients about the support that is available to them in the form of pharmacological support.

The final aim of the brief intervention is to, if appropriate, help the patient progress to the next stage of the quitting process. This may include arranging a referral to local NHS stop smoking services after discharge from hospital.

4.7.2 Intensive Intervention

Taken together, studies of hospital-based stop smoking interventions suggest that increasing the intensity of intervention, in particular by increasing the amount of follow-up contact, is associated with higher rates of quitting (Rigotti et al)

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In some cases, a hospital-based service may be well placed to provide this form of intensive support. Such cases may include when a patient is admitted over a lengthy period, when quitting smoking is a matter of particular, medical urgency or when a patient specifically requests further support while in hospital.

The aim of more intensive interventions should be to allow more time for the patient to explore his or her smoking and their feelings regarding quitting. Motivation, as a function of both the desire to quit, and confidence in one's ability to quit, is focused upon.

Intensive interventions should only be provided by selected, appropriately trained staff and in close collaboration with staff from the local NHS stop smoking service.

4.8 Provision of Pharmacological Support

In March 2002 the National Institute for Clinical Excellence (NICE) published its Technology Appraisal number 39 – "guidance for the use of nicotine replacement therapy (NRT) and bupropion for smoking cessation". This guidance supported the prescribing of NRT and bupropion as part of an abstinent-contingent treatment.

NRT is available in several forms including Transdermal patch (16 and 24 hour); Gum (2mg and 4mg); Lozenge (1mg, 2mg and 4mg); Inhalator (10mg cartridge); Microtab (2mg sublingual tablet) and Nasal spray (10mg per ml). Ideally the full range of products will be kept as stock by the hospital pharmacy

Bupropion (Zyban) is a non-nicotine smoking cessation aid that is licensed as a prescription only drug. Although some hospitals do have this product on their formulary it's use among hospital in patients is minimal for 2 reasons. First, Zyban needs to be taken for at least 1 week before quit date as it is a slow release formulation. Second, Zyban has a side effect profile, which is unpredictable for individuals. If side effects

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develop they may mask or become or confused with the patients reason for admission. There are also drug interactions to be considered with this treatment.

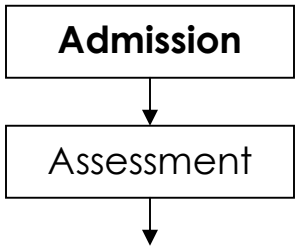
It is essential to get medications included in the hospital formulary, this cannot be achieved without the help of the pharmaceutical committee and senior pharmacists. Pharmacists can be a very good source of support for stop smoking services in a hospital setting. Offering Level 1 training and further information about the products to this group of staff can be very beneficial as they can be a source of referral as well as support for ward staff and doctors in the use and supply of medication.

A major hurdle to overcome can be how these products will be financed especially if the products have not been kept before. It is important to remember that they are NICE approved drugs. Some areas have used Patient Group Directions allowing appropriately qualified staff to supply the product to the patient without a prescription.

4.9 Provision of intervention pre- and post-discharge

Stop smoking interventions carried out in a hospital setting may benefit greatly from follow up work. Follow up interventions beyond the point of discharge may also help reinforce the gains made in previous intervention sessions in the patient's natural, home environment. Figure 4 shows the progress of patients through and beyond hospital-based service.

Figure 4: Progress of patients through and beyond hospital-based service



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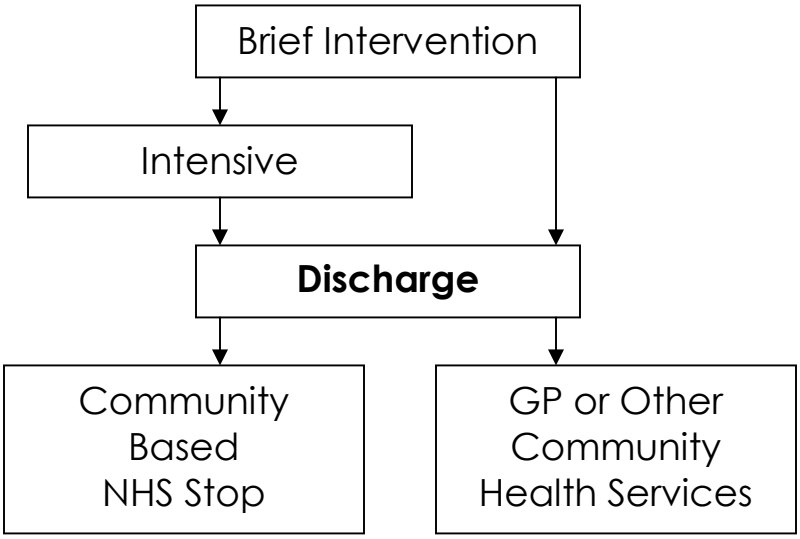

Where possible, stop smoking intervention should become established within the day-to-day routine of a ward or clinic. This will decrease the likelihood of patients slipping through the net and not being offered stop smoking support.

In all cases, it is important that hospital-based intervention is followed up In the community. The ideal setting for intervention after discharge will be the local, community-based NHS stop smoking service. In other cases, referral may be made to General Practitioners, or in the case of mental health patients, Community Psychiatric Nurses.

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5. Programme Implementation: Challenges and Solutions

OBJECTIVES

- To identify some potential barriers to the successful provision of stop smoking interventions in hospital settings.
- To distinguish between barriers common to all hospital settings and those more likely in psychiatric settings.
- To offer potential, workable solutions to common barriers

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5.1 Introduction

The successful implementation of any stop smoking programme will require that certain challenges are overcome. Some of the challenges that are likely to emerge in a hospital setting are discussed in this section along with suggestions as to how they may be overcome. The implementation of these solutions is illustrated, where appropriately, in the form of a vignette.

In this section, the emphasis is on finding as direct a solution as possible to each particular challenge and on utilising existing resources. Section 5.2 deals with challenges that may be encountered in any health care setting. Section 5.3 discusses issues that are more likely in, though not exclusive to, a psychiatric setting.

5.2 Challenges in all hospital settings

There are a number of challenges to be faced in a hospital setting. These are examined in the following sections.

5.2.1 Guidance on Smoke Free Policy

Guidance for implementing smoke-free hospital trusts from the Health Development Agency (HDA, 2005) makes it clear that smoking should not be permitted anywhere within hospital buildings. The HDA's five steps to becoming smoke free hospital trust are as follows:

1. Commit to the policy. Identify a champion responsible for implementation. Secure commitment at the top. Set up a working party. Identify the financial and human resources needed. Consider making grounds as well as buildings smoke free.

2. Create and draft the smoke free policy. Consult widely. Anticipate any problems. Finalise the policy. Ensure the timescales for implementation are adequate, including the lead-in period.

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3. Ensure cessation support is widely available. Advertise local NHS stop smoking service. Offer smoking cessation training to healthcare staff.

4. Communicate the policy. Adopt and advertise a firm date for implementation. Communicate the policy requirements - both internally and externally.

5. Consolidate the policy and then introduce it. Enforce it through regular communications. Ensure rigorous monitoring, making all staff responsible for implementation. Review the smoke free policy at least once a year.

While it is beyond the scope of this toolkit to consider this guidance in detail, one criticism of these steps that is relevant here is the order in which the five steps are placed. In particular, the order may be seen to imply that cessation support only becomes a priority after a smoke free policy has been committed to, drafted and sent out for consultation. It is the view and experience of the present authors that, ideally, the step of providing cessation support is best thought of as step one, and that a linked up system of referral and cessation intervention for both staff and patients should be in place some time before a smoke free policy is implemented.

If a smoke free policy is announced and sent out for consultation before a hospital based system of cessation support is in place and well promoted then the policy is likely to be criticised as being blind to the highly addictive nature of smoking, and the difficulty many staff and patients will experience when not allowed to smoke. This in turn will make a negative reaction to the policy more likely and therefore impede is subsequent implementation.

On the other hand, ensuring that a full stop smoking programme is in place before embarking on policy implementation will often have the advantage of helping to address the place of smoking within the culture of the organisation (a particularly salient issue in mental health settings – see section 5.3.1). One example of how this may be achieved is the use, within the smoke free policy communications strategy, of ‘case studies’ of staff or patients (with their consent) who have successfully quit as part of the hospital based cessation programme.

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Furthermore, if the plan for stop smoking support is implemented according to the guidance in this toolkit, the smoke free policy will also benefit form being preceded by a widespread system of staff training in brief cessation support, enabling staff not only to move patients towards quitting, but also to help them cope better with an enforced, temporarily abstinence during hospitalisation and the withdrawal symptoms that will inevitably be experienced.

5.2.2 Adherence to no-smoking policy

The importance of smoke-free policies in NHS trusts lies in the recognition that second hand smoke adversely affects the health of all employees and patients. Such policies also ensure a supportive environment for those who wish to stop smoking.

Specialist stop services should be advertised to both staff and patients, and made accessible to them. The introduction of smoke-free policies is not always met with universal acceptance and if mismanaged can lead to paradoxical reactions from both smoking and non-smoking staff. What is more, the level of adherence to smoke free policies has been shown to depend on several key factors in the implementation and operation of policies.

The importance of revisiting policies, auditing performance and modifying policies to increase effectiveness is emphasised by the Health Education Authority report on improving the effectiveness of tobacco control in the NHS. This document provides practical advice on the implementation, auditing, modification and re-launch of smoke-free policies in the NHS in addition to a policy monitoring tool which can be modified for specific needs. The key areas for monitoring are given as a basis for a substantial audit trail of policy performance that can be used as a basis for policy modification:

- Is compliance monitored in designated smoke free areas?
- Assess whether signage clearly conveys where smoking is restricted and where it
- is allowed?
- Has the policy been added to job advertisements?

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- Is the policy bought to the attention of new staff at induction?
- Are existing staff reminded, and new staff informed about stop smoking assistance?
- Are tobacco products sold anywhere within the Trust?
- Do patients receive notice of the policy prior to, or on, admission?
- Are all waiting areas, outpatient clinics, restaurants or canteens clearly signed as non-smoking?

A focus on these elements will increase the adherence non-smoking policies and, as already discussed, provide a culture and an environment where the services for patients who wish to stop smoking will have the best chance of success.

5.2.3 Staff attitudes and perceptions

The success of a hospital based stop smoking programme will depend heavily on the attitudes and perceptions of the hospital staff, and particularly those being asked to deliver interventions to patients.

Data from part of an ongoing survey carried out among NHS hospital trust staff by the authors of this toolkit (N=1523) suggests that, on the whole, staff are positive about their role in stop smoking support. For example, 77% of those that responded felt that staff should be offering stop smoking advice to patients on routine basis, 72% saw the implementation of a hospital-based stop smoking service as a positive move and 76% agreed that staff training in stop smoking intervention was a good idea. In all cases, less than 10% of staff indicated that they disagreed with the implementation of routine advice, a hospital-based service or stop smoking training.

One important issue affecting staff perceptions is that a proportion of staff will be smokers themselves, either habitually, or as occasional 'social' smokers. Data from the survey of staff suggests that 13% of staff were smokers (see figure 5)

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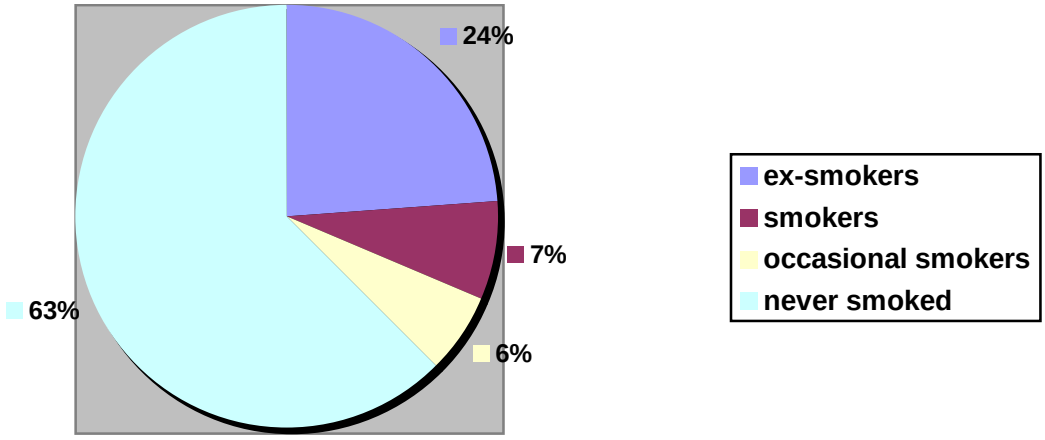
Figure 5: Smoking status of staff (N=1523)



5.2.4 Engaging senior staff

During the implementation of a stop smoking programme, attitudes to the programme may vary markedly among senior staff members (e.g., ward managers). This, in turn, will impact on the success of the programme in individual clinical teams.

Teams led by managers with a more positive attitude to the programme will allow more nurses to be trained in the programme, and also allow nurses more time to conduct interventions.

The impact of the attitude of senior staff to the programme should, in the first instance, be addressed by encouraging team managers to train as trainers and join the training team.

The involvement in training should raise their awareness of the potential value the programme and dispels any misconceptions they might hold about the programme.

Involving senior staff in training is also likely to influence junior staff members, both in terms of enthusiasm filtering down through staff grades, and through enabling managers to deal more effectively with any concerns that are brought to them by junior staff regarding intervention delivery.

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VIGNETTE: Engaging Senior Staff

On approaching the manager of a psychiatric ward, the directorate representative encountered a reluctance to support the programme. The manager felt that the interventions could aggravate patients and harm the relationship between them and his staff.

The manager was presented with an outline of the training programme and the 'patient-centred' nature of the intervention was emphasised. The representative encouraged the ward manager to become a trainer along with his deputy.

This proposal was agreed by both members of staff and they joined the first group of nurses to be trained as stop smoking trainers within the organisation.

5.2.5 Time constraints of senior staff: 'Co-ordinating' Staff Members

The day to day running of a stop smoking programme may be compromised by the other, significant time demands on clinical team managers.

The demands a stop smoking programme places on senior staff can be alleviated by identification of a 'co-ordinating' staff member within each team.

A number of responsibilities can be deferred to a stop smoking 'co-ordinator'. These responsibilities are designed for staff at all levels of seniority (that is, from newly qualified health professionals upwards). They are also designed to involve a minimal amount of time commitment and not interfere with routine workloads. Possible responsibilities include:

- liaison with the team manager regarding the stop smoking programme

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- identification of patients eligible to receive intervention (eg – from new admissions)
- organising regular team meetings to discuss the stop smoking work

Selection of co-ordinating staff may be best done on the basis of their enthusiasm and commitment to the stop smoking work. This may become apparent during or soon after completion of training.

VIGNETTE: Employing Co-ordinating Staff Members

During the training session for a ward newly recruited to the stop smoking programme, a nurse mentioned that she ran a 'healthy lifestyle' group on Monday mornings. On completion of the training the nurse was asked if she would co-ordinate the running of the programme on her ward.

A regular meeting between the ward manager and this nurse was scheduled to take place after this group, where they would discuss how the programme was running. This nurse also organised a monthly meeting and social event involving all the nurses trained in the stop smoking programme in her team. In these meetings she made a note of any issues raised and reported these back to the programme team.

5.2.6 Pharmacological Support

Issues encountered in supplying stop smoking medications in hospital settings include the failure to get medications added to the hospital formulary. This may result from there being no identified funding and / or a reluctance to stock all medications.

Some areas have used Patient Group Directions allowing appropriately qualified staff to supply the product to the patient without a prescription. A Patient Group Direction is a written direction, signed by a doctor and a pharmacist, relating to supply and administration of a prescription only medicine. They can be authorised by health authorities and NHS Trusts.

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Many barriers to the efficient supply of pharmacological supplements can be achieved with the help of the pharmaceutical committee and senior pharmacists. Pharmacists can be a very good source of support for stop smoking services in a hospital setting.

In particular, offering training (at level 1) to this pharmacy staff can be very beneficial as they can be a source of referral as well as support for ward staff and doctors in the use and supply of medication.

5.2.7 Patient response to services

Patients will inevitably differ in relation to their attitudes to smoking and the idea of quitting. While many patients are concerned about their smoking and will respond positively to stop smoking advice and support, a proportion may be less inclined to the idea of quitting and be less receptive to a stop smoking service.

Work carried out as part of the Reduction in Tobacco Addiction (RETAD) programme (see section 1.1.2) on hospital-based stop smoking programmes has revealed that the majority of patients to whom it is offered will positively receive a hospital-based stop smoking programme. Figure 6 shows that nearly 60% of patients offered stop smoking support during their time in hospital expressed their acceptance of this support.

The significant number of patients not responding positively to offers of stop smoking support within a hospital-based service represents a barrier towards effective implementation across an organisation. In particular, these patients may be less likely to adopt a positive orientation towards the support they receive, thus reducing the efficacy of the programme.

Figure 6: Comparison of patient numbers recruited, non-eligible or non-consenting (N=750)

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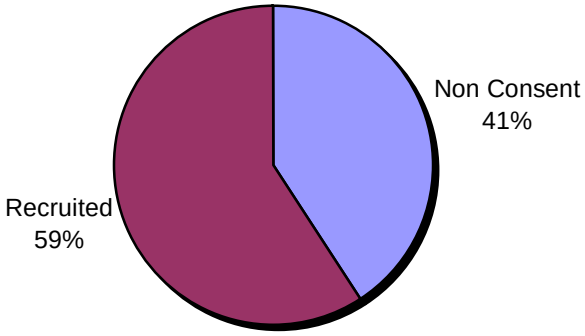

One reason for not wishing to receive such support commonly expressed by patients is the fear that the support will actually be stressful. In particular, patients fear that they will be rebuked by clinicians concerning their smoking and that the process will be intimidating.

This suggests a clear need for a 'patient-centred' approach to stop smoking support. From the outset, communication with patients regarding smoking should take into account the agenda and circumstances of the patient and not just the intentions of the clinician. Rather than using a dictatorial or confrontational style, those offering advice on smoking should come across to the patient as being 'on their side', and intervention sessions should clearly acknowledge how difficult quitting can be while avoiding communicating disapproval or blame. Sufficient time should be devoted to the positive consequences of quitting as well as the negative consequences of smoking.

5.2.8 Establishing and maintaining programme saliency

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In the period immediately following the training session for staff on a particular ward, the saliency of the stop smoking programme is likely to be high. However, as time goes on, other issues will come up and the stop smoking work may become less salient.

A list of ways in which visibility of a hospital-based stop smoking service can be maintained may include:

- Regular meetings between trained staff
- Publication of a programme newsletter
- Establishing a programme website
- Poster and leaflet distribution.

One way in which ongoing visibility may be achieved is through the organisation of regular, 'refresher' meetings between trained staff. In these meetings, staff can be given the opportunity to discuss issues related to intervention delivery, as well as keep up to date with new developments in stop smoking work.

Another method of maintaining the visibility of a stop smoking programme across a site is the creation of a programme 'newsletter'. According to the resources available, copies of this may be distributed quarterly or monthly to all wards and teams involved in the programme, as well as to local stakeholders and the local community.

The newsletter content should be aimed at encouraging involvement in the programme of new teams as well as reinforcing the involvement of existing teams. Thus, the information given in each issue should always include a brief explanation of the programme and its aims, as well as contact details for further information.

Contributions to the newsletter in the form of letters or articles should be encouraged, particularly from trained staff members.

Another way in which programme visibility can be maintained is through the establishment of a programme website. Ideally, this website would be hosted on the servers of the institution in which the programme is being held, and promoted via mutual, external links

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to relevant organisations (e.g. – stop smoking service websites) as well as by submission to generic search engines.

The content, while depending on the resources available, should aim to be interactive, possibly with a link to a forum to which staff may contribute and on which the programme team may disseminate information. The website may benefit from linking to the newsletter by publishing the latter as a portable document format (pdf) file.

Programme visibility can be maintained through the distribution of leaflets and posters around the local hospital site. Ideally, this would be in conjunction with an existing publicity programme such as that promoting an NHS trust no smoking policy.

Programme saliency may be supported by the regular presentation of the programme aims and structure at local Research and Development events and NHS trust conferences.

5.3 Challenges characteristic of psychiatric settings

There are many aspects of health care in psychiatric settings that distinguish it from general medical settings, and that are in need of consideration when implementing a hospital based stop smoking programme.

Salient issues concerning psychiatric settings relate to both the patients circumstances and the culture within which care is provided.

5.3.1 Smoking within the culture of psychiatric care

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Even though most NHS Trusts employ a no smoking policy for hospital buildings and clinical areas, smoking is still permitted in some psychiatric wards, sometimes in designated smoking lounges provided on wards.

When conducting training programmes with psychiatric nurses, it is advisable that time is devoted time to exploring the challenges of establishing a stop smoking service in a psychiatry setting.

Issues concerning the place of smoking in psychiatric care can be revisited in ongoing meetings organised between trained nurses.

5.3.2 Admission and discharge

One challenge on acute psychiatric wards is that, more frequently than on general wards, newly admitted psychiatric patients are often unable to respond to stop smoking intervention. For example, they may be disorientated and could be experiencing a level of distress that leaves them unable to concentrate.

Once patients have become more stable, they are likely to be able to participate in an intervention. However, due to the ongoing shortage of beds and staff, such improvements in condition often lead to early discharge of the patient from the ward.

These patterns of admission and discharge will lead to many potential participants in the stop smoking programme being missed. Targets, in terms of the number of interventions to be completed, should be realistic and reflect this difficulty.

Where a patient is unable to receive an intervention on admission, one way of addressing this challenge in psychiatric wards is, to allocate a specific nurse to deliver a stop smoking intervention with the patient as soon as possible thereafter. This nurse should be asked to check the patient's suitability for intervention at the start of every shift they work.

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Team managers may also address this issue by establishing lists, to be displayed in nursing offices, of all patients who smoke but have not yet received intervention. Nurses should be asked to check patients on the list on a regular basis for their suitability for intervention.

5.3.3 Contact after discharge

In a psychiatric setting, one major barrier faced by a stop smoking programme that goes beyond the admission period will be locating patients for referral to the local NHS stop smoking service further intervention after discharge.

A large proportion of patients admitted to acute psychiatric wards are of no fixed abode, moving around various hostels and care homes. This may be particularly true in large, urban areas, and resulted in a significant number of patients being lost to any intervention beyond the hospital stay.

In depth contact details should be gathered from the patient, and if possible, asking how they feel they could be contacted in the near future.

5.3.4 Cessation of Smoking and Medication associated with mental health disorders

An important consideration in the implementation of any stop smoking programme aimed at mental health service users is the potential of smoking, and therefore cessation, to affect the metabolism of certain medications.

Tobacco smoke has byproducts, such as polycyclic aromatic hydrocarbons, that induce cytochrome P450 isoenzyme 1A2 (CYP1A2). This enzyme, in turn, is important in the metabolism of many antipsychotic medications. If a smoker quits, then this enzyme induction is reduced and there will the metabolism of the drug will be slowed. A rise in levels of the drug will likely result, and potentially, a corresponding rise in side effects experienced by the patient. A list of drugs both those used in psychiatric treatment and

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others, that may be affected, is below (from *Smoking and Patients with Mental Health Problems,* (HDA 2004).

Caffeine	Clozapine
Diazepam	Fluvoxamine (partly)
Haloperidol (partly)	Mirtazapine (partly)
Olanzapine (partly)	Paracetamol
Perphenazine	Propranolol
Tamoxifen	Theophylline
Verapamil	Warfarin-R (major)
Zotepine	Tricyclics – tertiary (eg amitriptyline, clomipramine, desipramine, imipramine)

(Source: HDA, 2004)

Of particular concern is Clozapine. Pinninti et al (2005) point out that Clozapine as a much narrower therapeutic index compared to other drugs that may be affected (such as olanzapine), and that several of clozapine's side effects are dose related. They estimate that that, in a patient on clozapine who smokes, smoking cessation would probably cause an average patient's blood clozapine level to increase by 1.5-fold two to four weeks later.

The most important implication of these pharmacological effects for stop smoking programmes is that close liaison must be maintained throughout a quit attempt between the stop smoking advisor and the clinician prescribing the patients medication. Another implication is that prescribers should be made fully aware of the potential for metabolism changes in response to smoking cessation so that any changes in a patients condition are not misinterpreted. Consultation with the hospital pharmacy team is therefore advised when designing training programmes in smoking cessation for mental health staff.

5.3.5 Smoke Free Policy in Mental Health Settings

The extent to which the introduction of a smoke free policy may clash with the culture of mental health care (as discussed in section 5.3.1) should not be underestimated. Concerns are likely to be expressed, often vehemently, by both patients and staff regarding the policy and the consultation process should be given particular attention.

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Any communications strategy should have at its centre the premise that failing to provide a smoke free environment may put staff, as well as patients, at risk. Just 30 minutes exposure is enough to reduce coronary blood flow (Otsuka, 2001). Previous research has demonstrated that nurses regularly exposed to passive smoking at work were found to be 49% more likely to develop coronary heart disease (Kawachi, 1997). Objections that air cleaning systems or smoking rooms are already in place to combat these effects should be countered with the evidence that ventilation systems and designated smoking areas provide little to no protection from the harmful effects of tobacco smoke (Cains et al, 2004; Repace, 2003).

One particular fear that will often be expressed by mental staff is that smoking prohibition will create challenges in terms of ward disruption, or that smoking cessation efforts will be ineffective among patients with mental health problems. While these fears should be taken seriously, reassurance can be found from previous research. Smoking prohibition has consistently left ward disruption either unchanged (Haller et al., 1996), or improved (Hempel et al. 2002, Quinn et al. 2000). Staff attitudes to smoking bans have invariably improved after implementation (Dingman et al. 1988, Haller et al., (1996).

The issue of human rights may also be raised, especially where patients are in long stay units and where the health care setting is, to all purposes, their home. Indeed, article 8 of the Human Rights Act 1998 does provide for the right to respect for a person's private life. However, this right would usually be seen as a "qualified right" and may be unlikely to override the protection of others (from, for example, the effects of passive smoking). On the other hand, exposing people, who are resident in hospital to the effects of passive smoking, especially if they are there against their will, could well be considered an infringement of human rights. According to most human rights standards, every human being has the fundamental right to the *highest attainable standard of health*. This right is asserted in Article 25(1) of the Universal Declaration of Human Rights and in Article 12 of the International Covenant on Economic, Social and Cultural Rights. Relevant to this is that the WHO Framework Convention on Tobacco Control (which the UK has ratified) makes clear that relevant to the protection of the *human right to health*, the need to take measures to protect *all* persons from exposure to tobacco smoke is paramount.

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6. Frequently Asked Questions

It is hoped that this toolkit will serve as a comprehensive guide to the implementation of a hospital based stop-smoking service, and with this in mind, the intention has been to provide comprehensively and in a logical and useful order. However, the toolkit is also intended as a reference guide for those who may wish to find answers to specific questions or problems quickly and easily. The following 'frequently asked questions' section aims to facilitate this by providing brief information on several main issues and 'signposting' the reader to sources of further information within the main part of the toolkit.

FAQ 1: Why do we need a hospital-based stop smoking service?

With well over a hundred thousand people in the UK being killed by smoking every year, and the enormous costs to the NHS of smoking related illnesses, stop smoking support has become a national priority. There are many reasons why patients using hospital services represent a sizeable and potentially viable sector of the population for stop smoking intervention. *See section 1.1.1 for more on this.*

FAQ 2: Who should the stop smoking service be aimed at?

A brief, stop smoking intervention should be delivered to *all* patients using the hospital services who smoke *(see section 4.7.1)*. Clinical staff, as part of their routine work, deliver the intervention. It only takes a few minutes, but it can prove effective in moving people

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closer to a quit attempt, especially if combined with a referral to local stop smoking services. In some cases, additional and more intensive intervention may prove appropriate *(see section 4.7.2).* Selected staff that have received additional training can deliver this type of intervention.

Of course, the hospital environment also includes relatives and carers. There is no reason why one cannot give advice about smoking to patients in the presence of relatives and carers (with permission from the patient). By including relatives, those who may be supporting someone in contemplating about stopping smoking and stopping smoking can also participate in the discussion. If relatives or carers ask for further help for themselves they can be provided them with information on the local NHS stop smoking services.

FAQ 3: What about our staff? How will this affect them?

Smoking can be an important issue for staff, either because they are smokers themselves, or because they have experienced smoking related illness among family or friends. *Section 4.5* provides more information on how to support staff in either case. Staff members will benefit from the training they receive in stop smoking support, learning skills that they will be able to apply in range of settings. *Section 4.4* provides more information on staff training, which is also discussed further in this FAQ section *(see FAQ 7)*.

FAQ 4: Who will need to be involved in setting up the service?

The establishment of an effective infrastructure of key players in the implementation of stop smoking service is a necessary first step *(see section 3.1 for an overview)*. It is expected that the Chief Executive of the NHS Trust concerned, in close collaboration with the local NHS stop smoking service *(see section 2.1),* will provide overall leadership in the implementation of the hospital based stop smoking programme. A working group should be established *(see section 3.3)* that also includes key representatives from the hospital organisation. Central to this working group will be a 'clinical champion' who acts as an advocate for the stop smoking service *(see section 3.2*), as well as senior members of the

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local pharmacy service *(section 3.7)* and clinical directorate representatives *(see section 3.3)*.

FAQ 5: What resources will be needed?

Before implementation, a review will be required to ensure that the annual budget includes costing that will enable smoking interventions to be delivered successfully *(see section 3.8)*. Adequate resources will be needed to facilitate programme implementation, including staff training and pharmacological treatment. During the first year of development, a particular area for consideration may be the additional funding needed to facilitate staff training across the organisation *(see sections 3.5 and 4.4)*.

FAQ 6: What needs to happen before a service can be set up?

A number of key stages in the process of implementing of a hospital-based stop smoking service can be identified *(see section 4.1 for an overview).* A programme launch will help promote the service and demonstrate commitment from senior managers of the organisation, stakeholders and the local community *(see section 4.2)*. A period of self-assessment within clinical teams will also be of value in order to identify key factors or preconditions that need to be considered if implementation is to be successful *(see section 4.3 and appendix 2 for a self-assessment tool).* In addition, an initial staff training drive should be undertaken with the aim of training all existing and appropriate staff in the provision of stop smoking *interventions (see section 4.4).*

FAQ 7: Which staff can provide stop smoking interventions and how should they be trained?

In the 2004 white paper "Choosing Health" it is stated "Every member of NHS staff has the potential to increase their role in raising people's awareness of the benefits of healthy living." The aim of a hospital based stop smoking service should therefore be that *all* qualified health professionals are able to deliver at least the brief interventions *(see*

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section 4.7.1). This can be a nurse, doctor, pharmacist, occupational therapist, physiotherapist, radiographer, social worker or other professionals involved in care. It is the responsibility of the hospital organisation to identify staff appropriate for training. In particular, it is important that a trust-wide policy exists on whether health care assistants are permitted to undertake this type of work. If the Trust has an agreed policy, it is then a local decision at ward level on the suitability of staff to undertake smoking prevention and intervention work. Health care assistants can be very important members of the team in delivering health care when trained for such work *(see section 4.4)*.

A training team should be set up centrally within the organisation. Training should be organised and delivered as part of the overall strategy and guidelines of the local NHS stop smoking services and not as a completely separate, hospital-based initiative *(see section 3.5)*. Following the initial training drive, a regular schedule of training courses should be conducted. These training courses can be aimed at new staff members as well as any existing staff referred (or referring themselves) for extra training *(see section 4.4).*

FAQ 8: What is meant by 'self-assessment' and how is it be carried out?

A hospital-based service should promote, where possible, ownership to the clinical teams in which the service will operate. There are a number of key factors or preconditions that need to be considered if implementation is to be successful *(see section 4.3).* These factors may be identified through a self-assessment exercise within clinical teams. A self-assessment tool for team managers involved in implementing smoking cessation services is included in this toolkit *(see appendix 2)* that can be modified for management or clinical team use.

FAQ 9: What about 'Nicotine Replacement Therapy' and 'bupropion'?

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Pharmacological supplements, such as nicotine replacement therapy (NRT) and / or bupropion (Zyban) will be crucial in any stop smoking programme. From the outset, therefore, a hospital-based stop smoking service should actively engage the local pharmacy teams *(see section 3.7).*

NRT, which is available in several forms, can to some extent alleviate the distressing symptoms of nicotine withdrawal and greatly enhance the likelihood that a smoker will successfully quit. Bupropion (Zyban) is a non-nicotine medication that is licensed as a prescription only drug and is less widely used than NRT due to the potential for side effects *(see section 4.8)*

It is important that medications, particularly NRT, are included in the hospital formulary. This cannot be achieved without the help of the pharmaceutical committee and senior pharmacists and is another good reason from their engagement from the outset in a hospital-based stop smoking service.

FAQ 10: So, what problems are likely to come up?

It is inevitable that, in the implementation of any stop smoking programme, certain challenges will arise that need to be overcome. This toolkit, on the basis the experiences gained from implementing stop-smoking work within three NHS hospital settings, identifies some of the main barriers that may arise and discusses how they may be approached. *Section 5.2* deals with challenges that may be encountered in any hospital-based setting, while *section 5.3* discusses issues that are more likely in, though not exclusive to, psychiatric settings.

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Appendix 1: Information Resources

Smoking & Health

Department of Health. "Choosing Health: Making healthier Choices Easier" London: The Stationery Office, 2004.

Department of Health. "Smoking Kills: A White Paper on Tobacco." London: The Stationery Office, 1999.

Jarvis M, Wardle M (1999). Social patterning of health behaviours: the case of cigarette smoking . In: Social determinants of health. Eds: Marmot M, Wilkinwon R. OUP, Oxford 1999. Pp 2240-55.

Rigotti NA, Munafo MR, Murphy MF, Stead LF. Interventions for smoking cessation in hospitalised patients. Cochrane Database Syst Rev. 2003;(1):CD001837.

"Been there done that " revisiting tobacco control policies in the NHS
Our Healthier Nation HEA 1999

Practical Skills

Rollnick, S., Mason, P., & Butler, C. (2000). *Health Behaviour Change: A Guide for Practitioners*. Edinburgh: Churchill Livingstone

Miller, W. & Rollnick, S. (1991) *Motivational interviewing: Preparing people to change Addictive Behaviour*. New York: Guildford

Web Based Resources

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The Department of Health's 'Don't give up giving up' campaign was launched in December 1999. The website has links to the NHS Smoking Helpline (0800 169 0 169), local stop smoking services and a lots of health information & resources.
http://www.givingupsmoking.co.uk/

Action on Smoking & Health (ASH) is a campaigning public health charity. They are a great source of leaflets, posters, images and presentations all geared to educating people against smoking.
http://www.ash.org.uk/

QUIT is an independent charity whose website offers a wealth advice and support for those wishing to give up smoking. You can also phone their free 'Quitline' at any time for confidential help and advice (0800 00 22 00).
http://www.quit.org.uk/

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Appendix 2: Self-assessment tool

This tool will enable clinical teams or organisations to examine themselves and the day-to-day systems they operate. The aim is to identify strengths and areas for further development in relation to stop smoking service implementation. The tool uses the same format and rating scale as the Commission for Health Improvement's self assessments that many teams will be familiar with. To complete the self-assessment, it may help you if you carry out the following steps for every statement:

1 Read the statement and the underlying guidance. Ensure that you are clear about what the statement is looking for.

2 Discuss as a team where you are in relation to the statement, using the guidance to structure your discussions. Identify your key strengths and areas where progress is most needed, and think about any constraints you face.

3 Note down the key points of your discussions in the space where you are asked for your comments. This will be a helpful reference in the future, if you decide to repeat the self-assessment.

4 Reflecting on your discussions, agree your position on the rating scales provided. Indicate the box that most closely represents your views.

5 Once you have completed all the statements, you may like to review all of your responses and identify three key actions to take forward. These could then be integrated into other action planning cycles.

6 Name all the participants on the final page. This will help you to keep a record of who has been involved and may be useful if you wish to repeat the self-assessment in the future.

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SELF-ASSESSMENT RATING SCALE - 1

To what extent is this statement met for your team?

Scarcely, if at all	There are few, if any, examples where this is true, and our team has no plans to address this issue.
Slightly	There are few, if any, examples where this is true, but an approach is being developed, OR There are isolated examples of this being addressed.
Somewhat	There are increasing numbers of examples of this being addressed, and we are enthusiastic about development, but an approach is still being developed, OR An approach has been developed, but with the exception of a few enthusiasts there has been little uptake on the ground.
Substantially	The issue is increasingly being addressed. The area is still relatively new, and the methods for dealing with it have not yet been fully evaluated. The activities in this area are not always integrated.
Strongly	We have made significant progress towards addressing this issue. The methods are now evaluated and mature and we increasingly look for further development and adaptation. This is increasingly seen by staff as 'part of the job'. The activities in this area are usually, though not always, integrated.
Fully	This is integral to what we do. All staff recognise and are committed to the importance of the issue and it is always considered as part of the services we offer.

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SELF-ASSESSMENT RATING SCALE - 2

How much influence do you have to improve this situation?

None	As a team, we have no direct influence over this issue.
Marginal	We do not have authority for this issue, and we have few channels of influence over those who could improve this situation.
Some	We have nominal authority for this issue, but this is not universally recognised and we have significant difficulties in making progress, OR We have no authority for this issue, but we have channels to influence those who do.
De facto	We do not have authority for this issue, but effectively we are able to influence most of what we do.
Strong	It is generally recognised that we have authority for this issue, but we usually need to negotiate solutions with others, and/or overcome significant factors outside our control
Full	It is recognised that we have authority for this issue and are able to ensure that improvements are implemented and monitored.

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Statement 1

Key players across and within organisations have endorsed the routine provision of smoking cessation

Guidance

Consider for example: how much support does this have from ward managers, modern matrons, senior clinical staff, and managers at all levels

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 2

Upper level management gives its support for a smoking cessation counselling program

Guidance

Consider for example: Has this been an item on a Trust Board agenda? Is there a senior executive with a lead role for this. Has the ward manager expressed support – who are the key players who you need to recruit to support the program?

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 3

A respected member of the team has offered to be a 'champion', with sufficient clout to overcome obstacles and gain the support of staff at all levels.

Guidance

Consider for example: work as a team through all the staff who could fit this role – how do you engage them?

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 4

A member of the team has personally volunteered to act as co-ordinator, assuming responsibility for ensuring that everyone does their tasks and that the cessation service is delivered consistently, effectively and sustained.

Guidance

Consider for example: who on the team is best suited to do this? Can this be done by one person? What support would they need?

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 5

The team is willing to have someone outside the team to facilitate the improvement process

Guidance

Consider for example: Where within the Trust could this support come from – what skills are needed – how valuable is this/

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 6

A system in place to routinely identify whether a patient smokes or not

Guidance

Consider for example: How many patients on your ward smoke ? Does everyone on the team know who they are – whose responsibility is it to identify them – what systems could you put in place to ensure that this happens?

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 7

The whole team is genuinely committed to improving how it manages smoking cessation.

Guidance

Consider for example: How would team members sabotage the program if they wished to ? How many smokers do you have on the team and what are their views

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 8

There is existing provision of education and/or feedback to staff pertaining to smoking cessation counselling and other treatments?

Guidance

Consider for example: What education would you need – how would it best be provided – how would you release staff for training – how would you find out if training is available

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 9

All staff are aware of the signs and implications of nicotine withdrawal?

Guidance

Consider for example: How many of your patients are suffering today? Where could the team get training on this issue?

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 10

All staff are aware of the management of nicotine withdrawal

Guidance

Consider for example: Do you have any educational resources available now – who on the team could take responsibility for organizing a training session

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 11

The team are fully aware of its smoking culture e.g. staff smelling of tobacco, talking about “social smoking”.

Guidance

Consider for example: what effect does a nurse “smelling of smoke” have on a patient who is suffering from nicotine withdrawal ? What help do staff need to stop smoking

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 12

The organisation has an effective non smoking policy in place

Guidance

Consider for example: What is the policy – when was it introduced? When was it last audited, monitored or revised?

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 13

The organisation has systems in place to help staff who wish to stop smoking

Guidance

Consider for example: Do staff have access to smoking cessation services, NRT therapy? How could this be organized.

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 14

The team has identified all the barriers to successful implementation of smoking cessation in their area.

Guidance

Consider for example: resource issues, knowledge issues, attitude issues, smoking behaviour and culture

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Statement 15

The team has identified all the resource issues which need to be addressed to ensure that smoking cessation will be available for all their patients who smoke.

Guidance

Consider for example: staff time, training, treatment costs, possible benefits ?

Use this space to record your discussions. You may find it helpful to think about areas of good practice and areas where progress is particularly needed.

To what extent is this statement met for your team?					
Scarcely if at all	**Slightly**	**Somewhat**	**Substantially**	**Strongly**	**Fully**
How much influence do you have to improve this situation?					
None	**Marginal**	**Some**	**De Facto**	**Strong**	**Full**

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Appendix 3: Patient Assessment Tool

Name_____ **Date**_____ **Team** _____

Are you currently a smoker? Yes No

Have you stopped smoking at the moment in an attempt to quit? Yes No

FAGERSTROM TEST FOR NICOTINE DEPENDENCE

1. How soon after you wake up do you smoke you first cigarette?

After 60 minutes	0
31 – 60 minutes	1
6-30 minutes	2
Within 5 minutes	3

2. Do you find it difficult to refrain from smoking in places where it is forbidden?

No	0
Yes	1

3. Which cigarette would you hate most to give up?

The first in the morning	1
Any other	0

4. How many cigarettes per day do you smoke?

10 or less	0
11- 20	1
21-30	2
31 or more	3

5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?

No	0
Yes	1

6. Do you smoke if you are so ill that you are in bed most of the day?

No	0
Yes	1

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ICD-10 Screen for Tobacco Dependence

Which of the following are true for you? Only tick a statement if is currently true and has been so far for *at least a month* or has occurred *repeatedly over the last year*.

My desire to smoke is usually strong.	
It's difficult for me to stop or cut down on my smoking.	
If I don't smoke for a long time I often become anxious, irritable or restless.	
The number of cigarettes I smoke each day is increasing over time.	
I try to avoid situations in which I can't smoke (eg – non smoking cafes or long flights)	
What I know about the dangers of tobacco doesn't really influence my smoking.	
Score	

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Motivation to Quit Smoking – Brief Patient Assessment

Importance of quitting

On the line shown below, please indicate how important quitting smoking is to you by putting a cross on the line

(0=not at all important 100=very important)

Confidence in ability to quit

On the line shown below, please indicate your current level of confidence in your ability to quit smoking by putting a cross on the line

(0=not at all confident 100=very confident)

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Appendix 4: Learning Module

Introduction

These four learning modules can be used for self-study or as part of a group exercise for teams starting to develop stop smoking programmes.

The modules present commonly raised issues for consideration. The module directs you to the relevant section of the toolkit and present abstracts of relevant papers.

The questions at the end of the module can be used to develop your own evidence-based approach to the issue.

Modules

1 Introducing a stop smoking project to a psychiatric ward.
2 What about the staff who smoke?
3 Engaging team managers.
4 Doctors and NRT.

The '4U' approach

1. Understanding the issue
2. Understanding the background
3. Understanding the evidence
4. Understanding what to do

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MODULE 1: Introducing a stop smoking project to a psychiatric ward.

1. Understanding the issue

On approaching the manager of a psychiatric ward, the directorate representative encountered a reluctance to support the programme. The manager felt that the interventions could aggravate patients and harm the relationship between them and patients.

2. Understanding the background

Read the key elements of the toolkit which are relevant to this vignette

-Section 4.3 Self-assessment within clinical teams

-Section 5.2.3 Engaging senior staff

-Section 5.3 Challenges characteristic of psychiatric settings.

3. Understanding the evidence:

a. Abstract from (Haller, McNiel et al. 1996)

BACKGROUND: This study prospectively evaluated the impact of a complete smoking ban on a locked psychiatric unit. METHOD: The setting was a 16-bed inpatient unit with 83% (134/162) involuntary patients, no off-unit smoking area, no possibility of granting smoking passes, and a mean length of stay of 2 weeks. The effect of a complete smoking ban was measured by surveys of both staff and patients before and after the ban. In addition, objective indicators of ward disruption were measured, including rates of aggression, use of p.r.n. medications, need for seclusion and restraints, elopement, and discharges against medical advice. RESULTS: Although staff initially expressed concern about the ban's potential negative impact, after it began, t tests revealed that staff were significantly ($p < .05$) less concerned about patients' needing more medication, becoming restless, being too fragile to cope with withdrawal, leaving the unit against medical advice, or trying to elope. Staff were significantly ($p < .02$) more positive about the ban than were patients. Although patients, overall, had negative views toward the new policy, their opinions were somewhat less negative after its implementation. Rates of assaultive

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behavior, use of seclusion and restraints, use of p.r.n. medication, and against-medical-advice or elopement discharges did not change after the ban was in effect. When polled, 78% (40/51) of the staff voted to keep the ban. CONCLUSION: This study found that staff anticipated negative consequences to a total smoking ban; however, their attitudes changed after it began. The ban had no significant impact on the ward milieu, and although patients were not in favor of it, they felt less negative over time.

b. Abstract from (El-Guebaly, Cathcart et al. 2002)

OBJECTIVE: Persons with psychiatric illnesses are about twice as likely as the general population to smoke tobacco. They also tend to smoke more heavily than other smokers. This critical review of the literature identified 24 empirical studies of outcomes of smoking cessation approaches used with samples of persons with mental disorders. METHODS: The authors conducted searches of large health care and other databases for the years 1991 through 2001, using the key terms smoking, smoking cessation, nicotine, health/hospital/smoke-free policy, and psychiatry/ mental/substance abuse disorders. RESULTS AND CONCLUSIONS: The majority of interventions combined medication and psychoeducation. Although the studies were not uniform enough to allow a meta-analysis, the recorded quit rates of patients with psychiatric disorders were similar to those of the general population. Clinicians could usefully devote more effort to smoking cessation in populations with mental illness or addictions.

4. Understanding what to do

Taking into account the information you now have from the Toolkit and the other sources of evidence :

a. How would you involve the ward manager in the programme ?
b. How would you investigate the smoking culture on the ward ?
c. Are the ward managers concerns valid ?

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MODULE 2: What about the staff who smoke?

1.Understanding the issue

Nursing staff on a surgical ward feel that they are not able to support the smoking cessation programme because many of the nurses smoke

2. Understanding the background

Read the key elements of the toolkit which are relevant to this vignette

-Section 4.5 Staff support systems

-Section 5.2.1 Adherence to no-smoking policy

-Section 5.2.2 Staff attitudes and perceptions

3. Understanding the evidence:

a. Abstract from (Becker, Myers et al. 1986)

We examined smoking prevalence, smoking behavior, and attitudes toward smoking in hospitals in 1,380 respondents among 1,719 registered nurses in a large urban teaching hospital. In this group, current prevalence of smoking in hospital nurses (22 per cent) was less than women in the general population (29 per cent). Smoking nurses were more likely than nonsmokers to hold attitudes which potentially reduce their efficacy in helping patients to stop smoking.

b. Abstract from (McKenna, Slater et al. 2001)

AIM AND RATIONALE: The preventable nature of smoking related diseases places a major responsibility for health promotion on all health professionals. This study used a questionnaire to survey qualified nurses in Northern Ireland as to smoking prevalence and their desire to quit the habit. It also explores their knowledge base relating to smoking related diseases and their motivation to act as health promoters with patients who smoke. METHODS: A random sample (n=1074) of qualified nurses employed by the Health and Social Services Trusts, private, and voluntary organizations in the province were surveyed. RESULTS: Results show that 25.8% were smokers, 19% were ex-smokers and 55.2% were nonsmokers. Three quarters expressed a wish to stop within 6-months. Almost all smokers and half of ex-smokers had taken up the habit prior to commencing nursing.

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'Addiction' and 'enjoyment' were given as the principle reasons for continued smoking. Health reasons were paramount in smokers' desire to stop smoking. CONCLUSIONS: These findings suggest that smoking prevalence among qualified nurses in no greater than that reported by females in the general Northern Ireland population. Results also indicate that those nurses who smoke were less willing to take on the role of a health promoter with patients who smoke. Implications and recommendations for practice, education and research are explored.

4. Understanding what to do

Taking into account the information you now have from the Toolkit and the other sources of evidence :

a. What support should be offered to staff who smoke?

b. What provision should be made for staff who are able to stop smoking?

c. What are the education and training needs of staff who smoke?

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MODULE 3: Engaging team managers

1. Understanding the issue

A team manager is reluctant to release her nursing staff for training in stop-smoking skills and feels that nurses are too busy and wont be effective.

2. Understanding the background

Read the key elements of the toolkit which are relevant to this vignette

- Section 2.1.1 Overview
- Section 4.4 Staff Training
- Section 4.7.1 Brief Interventions

3. Understanding the evidence

a. Abstract from Shuttleworth 2004

Smoking is a major cause of morbidity and mortality in the UK, and the government has funded a range of local and national smoking cessation initiatives. Supporting people as they attempt to give up smoking requires specialist skills and knowledge, often provided by nurses who have received appropriate training. However, non-specialist nurses can also play a role in cutting smoking rates by encouraging patients to consider giving up and directing them towards specialist services. This article focuses on the role that hospital-based nurses can play in encouraging patients to give up smoking.

b. Abstract from (Rigotti, Munafo et al. 2003)

BACKGROUND: An admission to hospital provides an opportunity to help people stop smoking. Individuals may be more open to help at a time of perceived vulnerability, and may find it easier to quit in an environment where smoking is restricted or prohibited. Providing smoking cessation services during hospitalisation may help more people to attempt and sustain a quit attempt. OBJECTIVES: To determine the effectiveness of interventions for smoking cessation in hospitalised patients. SEARCH STRATEGY: We searched the Cochrane Tobacco Addiction Group register, CINAHL and the Smoking and Health database in March 2002 for studies of interventions for smoking cessation in hospitalised patients, using terms including (hospital and patient*) or hospitali* or

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inpatient* or admission* or admitted. SELECTION CRITERIA: Randomised and quasi-randomised trials of behavioural, pharmacological or multicomponent interventions to help patients stop smoking conducted with hospitalised patients who were current smokers or recent quitters. We excluded studies of patients admitted for psychiatric disorders or substance abuse, those that did not report abstinence rates and those with follow-up of less than six months. DATA COLLECTION AND ANALYSIS: Two authors extracted data independently for each paper, with disagreements resolved by consensus. MAIN RESULTS: Seventeen trials met the inclusion criteria. Intensive intervention (inpatient contact plus follow-up for at least one month) was associated with a significantly higher quit rate compared to control (Peto Odds Ratio 1.82, 95% CI 1.49-2.22, six trials). Interventions with less than a month of follow-up did not show evidence of significant benefit (Peto Odds Ratio 1.09, 95% CI 0.91-1.31, seven trials). There was no evidence to judge the effect of very brief (<20 minutes) interventions delivered only during the hospital stay. Longer interventions delivered only during the hospital stay were not significantly associated with a higher quit rate (Peto Odds Ratio 1.07, 95% CI 0.79-1.44, three trials). Although the interventions increased quit rates irrespective of whether nicotine replacement therapy (NRT) was used, the results for NRT were compatible with other data indicating that it increases quit rates. There was no strong evidence that clinical diagnosis affected the likelihood of quitting. REVIEWER'S CONCLUSIONS: High intensity behavioural interventions that include at least one month of follow-up contact are effective in promoting smoking cessation in hospitalised patients. The findings of the review were compatible with research in other settings showing that NRT increases quit rates.

4. Understanding what to do

Taking into account the information you now have from the Toolkit and the other sources of evidence:

a. Is the use of nurses in exploring with patients the opportunities to stop smoking a good investment of time?

b. Why is it important that hospital stop-smoking services are linked with community services?

c. What level of training will be needed for most nursing staff ?

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MODULE 4: Doctors and NRT

1. Understanding the issue

The nurses on a cardiac ward are keen to get involved in a stop-smoking programme for the patients but there is resistance from the medical staff particularly about prescribing NRT

2. Understanding the background

Read the key elements of the toolkit which are relevant to this vignette

-Section 4.3 Self-assessment within clinical teams

-Section 4.8 Provision of pharmacological support

-Section 5.2.7 Pharmacological support

3. Understanding the evidence

a. Abstract from (Hobbs and Bradbury 2003)

INTRODUCTION: Smoking is the single most important aetiological factor for the development and progression of atherosclerosis. Unfortunately, most patients receive little or no treatment for their nicotine addiction. This review aims to make evidence based recommendations for smoking cessation as part of a comprehensive delivery of best medical therapy to patients with peripheral arterial disease. METHODS: A search of MEDLINE (1966 to 2003) and the Cochrane library was undertaken for studies relating to smoking cessation. Major priority was given to meta-analyses of randomised controlled trials including Cochrane reviews. RESULTS: Physician advise, nicotine replacement therapy and Bupropion are all evidence based treatments that have success in increasing the likelihood of permanent smoking cessation. A basic understanding of the psychology of addictive behaviour is essential so that appropriate advice and treatment can be tailored to individual patients. CONCLUSIONS: Complete and permanent smoking cessation is by far the most clinically and cost effective intervention in patients with atherosclerosis. Greater awareness of smoking cessation strategies, by clinicians treating vascular patients, is essential for the effective delivery of best medical therapy.

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b. Abstract from (Godfrey and Fowler 2002)

Smokers are more likely to develop a variety of serious diseases than non-smokers; the morbidity and mortality from these diseases place a great resource burden on society in respect of demands on healthcare resources and lost productivity. The cost to the healthcare system of treating the consequences of smoking is high. Given the availability of inexpensive pharmaceutical therapies such as sustained-release bupropion (bupropion SR) and nicotine replacement therapy (NRT), which are proven to be effective, there is economic advantage for governments and the medical profession in encouraging patients to quit. The cost effectiveness of effective smoking cessation support is far superior to that of many other potentially life-saving interventions and, indeed, the UK National Institute for Clinical Excellence (NICE) stated in April 2002 that "both bupropion and NRT are considered to be amongst the most effective of all healthcare interventions". Recent economic analyses have confirmed that the use of bupropion SR as an aid to smoking cessation is a highly cost-effective intervention.

4. Understanding what to do

Taking into account the information you now have from the Toolkit and the other sources of evidence :

a. What role could a pharmacist play in supporting doctors with regard to stop-smoking problems
b. What are the benefits of adding NRT to other interventions
c. What benefits would there be for doctors to become involved in delivering a stop-smoking programme for their patients?

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